STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155248	A. BUILDING _____ B. WING _____	C 02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-BRENTWOOD	30 EAST CHANDLER AVE EVANSVILLE, IN 47713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00085197, Complaint IN00085238, and Complaint IN00085244. Complaint IN00085197 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F312. Complaint IN00085238 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282. Complaint IN00085244 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 31, February 1 and 2, 2011 Facility number: 000152 Provider number: 155248 AIM number: 100267510 Survey team: Anne Marie Crays RN Census bed type: SNF/NF: 86 Total: 86 Census payor type: Medicare: 14 Medicaid: 62 Other: 10 Total: 86 Sample: 5 These deficiencies also reflect state findings in accordance with 410 IAC 16.2.	F 000	PLAN OF CORRECTION: Preparation, submission, and implementation of this POC does not constitute an admission of, or an agreement with the findings or the conclusions set forth in the survey report. Our POC was prepared and will be executed as a means to continuously improve the quality of care given to our residents and to comply with all Federal and State regulatory requirements. Golden Living Center- Brentwood desires this Plan of Correction to be the facility's' allegation of compliance. Compliance date is March 4, 2011. RECEIVED FEB 22 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Pamela L McElhiney | EXECUTIVE DIRECTOR | 2/21/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Quality review 2/06/11 by Suzanne Williams, RN	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure care plan interventions were implemented, in that Resident E was not checked for incontinence in a timely manner, Resident A did not receive milk with her meals, nor receive assistance with her meals, and Resident D did not have a bed alarm on her bed, nor went to the dining room or received restorative dining services for her meals, for 3 of 5 residents reviewed for implementation of care plans, in a sample of 5. Residents E, A, and D Findings include: 1. On 2/1/11 at 8:30 A.M. 9:45 A.M., and 10:30 A.M., Resident E was observed sitting up in a wheelchair by the nursing station. On 2/1/11 at 10:35 A.M., Resident B, who was indicated as alert, oriented, and interviewable by the Director of Nursing (DON) on 1/31/11 at 8:55 A.M., stated, "I bet if you check her [Resident E], she'll be wet." Resident B indicated Resident E had been sitting up in her wheelchair since 4:45 A.M. On 2/1/11 at 10:45 A.M., a skin assessment of	F 282	I. Corrective actions were made for the affected residents. (A) Resident A was offered milk by the nursing staff and was assisted by a CNA for meal, set-up. Resident initially refused and the CNA reported to the unit manager of the refusal and that she would reattempt later in the meal time. (B) Resident D had a bed alarm placed on her bed. She was assisted to the dining room and was assisted with her meal service. (E) Resident E was checked for incontinence and was given incontinent care with barrier cream. II. The facility recognizes that all residents have the potential to be affected by the alleged deficient practice. Residents with the potential to be affected were reviewed by audits of the ADL records, CNA assignment sheets, Physicians orders and the plans of care to identify those residents at risk. Corrections were made as necessary.	

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F 282	Continued From page 2 Resident E was requested. The Assistant Director of Nursing, LPN # 1, and CNA # 1 assisted the resident from the chair. The resident's pants were saturated through with urine. The resident's brief was completely saturated. Resident E's buttocks and upper thighs were reddened and creased from the wet brief. The clinical record of Resident E was reviewed on 2/1/11 at 11:00 A.M. Diagnoses included, but were not limited to, severe dementia. A Minimum Data Set [MDS] assessment, dated 1/10/11, indicated the resident had a short-term and long-term memory problem, was severely impaired in cognitive skills for daily decision-making, required extensive assistance of two + staff for transfer, and extensive assistance of one staff for toilet use. The MDS assessment indicated Resident E was "Frequently incontinent" of bowel and bladder. A current care plan, dated 6/30/10, was provided by the MDS Coordinator on 2/1/11 at 1:00 P.M. The care plan indicated a "Focus" on "Alteration in elimination of bowel and bladder, Functional incontinence, Diuretic Use." The Interventions included, "Check and change q 2 h [every 2 hours] and prn [as needed]." On 2/1/11 at 2:00 P.M., during an interview with CNA # 1, she indicated she had not gotten Resident E up that morning, but that she was already up at 7:30 A.M., when she reported for work. CNA # 1 indicated she was not sure when Resident E had gotten up, but she thought the resident was a "third shift get up." CNA # 1 indicated she had checked the resident for incontinence "some time" that morning, after she	F 282	III. The following measures were implemented to ensure that the alleged deficient practice does not recur: Education was provided to staff on following the residents plan of care to include the CNA assignment sheets. CNA assignment sheets were updated as necessary to provide timely incontinent care for residents dependent for toileting and personal hygiene. IV. The corrective measures will be monitored by audits of the residents requiring use of assistive devices and or assistance with feeding residents, and residents that are dependent for toileting and personal hygiene 3 times per week for 6 months and will be monitored monthly in QA&A until corrective actions are no longer needed. V. Corrections will be completed by March 4, 2011.	

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F 282	Continued From page 3 reported to work, and the resident had been dry. 2. On 1/31/11 at 9:15 A.M., the DON indicated Resident D did not require alarms for fall prevention. Resident D was observed lying in bed at that time, finishing her breakfast. On 1/31/11 at 12:15 P.M., Resident D was observed sitting in bed, with her lunch tray in front of her. On 2/1/11 at 8:30 A.M., Resident D was observed lying in a low bed in her room. Alarms were not observed on her bed. CNA # 1, during an interview, indicated at that time that the resident did not have any alarms, but "just a low bed and mats." CNA # 1 rolled up the head of the resident's bed, and brought her a breakfast tray in her room. The clinical record of Resident D was reviewed on 2/1/11 at 8:45 A.M. Diagnoses included, but were not limited to, Vascular Dementia. A Minimum Data Set [MDS] assessment, dated 1/12/11, indicated the resident had a memory problem, required extensive assistance of two + staff for bed mobility and transfer, and extensive assistance of one staff for eating. The MDS assessment indicated Resident D was not steady while moving on and off the toilet, and during surface-to-surface transfers. Physician orders, initially dated 5/28/10 and on the current February 2011 orders, indicated, "Pressure Alarm while in bed d/t [due to] decreased safety awareness - Every shift Everyday," and "Restorative Dining/Eating with cues supervision and encouragement to eat and	F 282		

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F 282	Continued From page 4 drink with one person assistance with set up assistance - Every shift Everyday." A care plan, initially dated 12/23/09 and updated 10/25/10, indicated a problem of "Risk for falls/injury d/t [due to] antidepressant medications." The Interventions included: "Pressure pad alarm while in bed." A care plan, initially dated 10/19/10 and updated 1/31/11, indicated a "Focus" of "Inadequate Oral Food/Beverage Intake due to: Continual weight loss..." Interventions included: "Take patient to dining room for meals." An additional care plan, initially dated 9/23/09 and updated 10/25/10, indicated, "Needs restorative care for: dining/eating." On 2/1/11 at 9:45 A.M., the DON looked around the resident's bed, and indicated she did not see an alarm on the bed. On 2/1/11 at 10:00 A.M., the DON indicated the restorative dining room is indicated for those residents who need cues or supervision with their meals. 3. On 1/31/11 at 9:15 A.M., during the initial tour, the DON indicated Resident A was receiving hospice services, and had weight loss. Resident A was observed at that time lying in bed. The clinical record of Resident A was reviewed on 1/31/11 at 11:45 A.M. Diagnoses included, but were not limited to, Alzheimer's Disease. A Minimum Data Set [MDS] assessment, dated 11/7/10, indicated Resident A had a memory	F 282		

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F 282	Continued From page 5 problem, and required extensive assistance of one staff for transfer and eating. Physician orders, initially dated 6/1/10 and on the current February 2011 orders indicated, "Resident to attend restorative dining/eating with each meal cues supervision and encouragement assistance required - Three times a day before meals everyday." A care plan, initially dated 8/9/10 and updated 1/27/11, indicated a "Focus" of "Leaves 25% of most meals, mechanically altered diet due to chewing, sig [significant] wt loss for 180 days...." The Interventions included: "Assist to RDR [restorative dining room] for Brk [breakfast] & L [lunch] & assist [with] all meals...offer 2 handled cup [with] meals to aid in fluids. Offer milk [with] all meals...." A progress note, dated 1/27/11 at 6:27 P.M., indicated, "Dietician's Note...Eats meals in restorative dining room and main dining room in evening...Also offered donuts at breakfast...Nutrition care plan reviewed. Uses two handled cup and offered milk all meals...." On 1/31/11 at 12:10 A.M., CNA # 2 was observed bringing a lunch tray into Resident A's room. CNA # 2 indicated the resident would tell staff if she wanted to get up or not. CNA # 2 indicated Resident A "could feed herself." Neither milk nor a two-handled cup was observed on the resident's tray. At 1:00 P.M. on the same date, Resident A's lunch tray was observed on the lunch cart. Milk was not observed on the resident's tray. On 2/1/11 at 8:20 A.M., Resident A was observed	F 282		

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F 282	Continued From page 6 lying in bed, with the divider curtain pulled, so as the resident could not be seen from the doorway. The resident was observed lying in bed, eating her breakfast. The resident was observed trying to eat with her spoon upside down. Neither milk nor a two-handled cup was observed on the resident's tray. Donuts were not observed on the resident's tray. The resident was not eating her fortified oatmeal. On 2/1/11 at 12:15 P.M., Resident A was observed lying in bed. Hospice staff was talking with the resident. The resident's lunch tray was beside the resident on her bedside table. Neither milk nor a two-handled cup was observed on the tray. On 2/1/11 at 2:15 P.M., the Dietary Manager [DM] was interviewed regarding the plan of care for Resident A. The DM indicated Resident A received assistance with her meals, and went to the restorative dining room for her meals. The DM indicated she or the dietician developed the care plans. The DM indicated since the care plan stated to "offer milk," staff would ask the resident if she wanted milk, not necessarily send it on the tray. The DM indicated she kept donuts on hand in the freezer in case the resident asked for them. The DM indicated she would try to provide anything the resident would ask for. The DM indicated she didn't think the resident liked milk anyway, and would have to update the care plan. When informed the resident had not been observed going to the restorative dining room, or being assisted with her meals, the DM indicated she had "no control over that." This federal tag relates to Complaint IN00085197 and Complaint IN00085238.	F 282		

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F 282	Continued From page 7 3.1-35(g)(2)	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident who was dependent for toileting and personal hygiene received incontinent care to meet the resident's needs, for 1 of 3 residents reviewed for incontinence care, in a sample of 5. Resident E Findings include: 1. On 1/31/11 at 8:55 A.M., during the initial tour, the Director of Nursing [DON] indicated Resident E was incontinent of bowel and bladder. On 2/1/11 at 8:30 A.M. 9:45 A.M., and 10:30 A.M., Resident E was observed sitting up in a wheelchair by the nursing station. On 2/1/11 at 10:35 A.M., Resident B, who was indicated as alert, oriented, and interviewable by the DON on 1/31/11 at 8:55 A.M., stated, "I bet if you check her [Resident E], she'll be wet." Resident B indicated Resident E had been sitting up in her wheelchair since 4:45 A.M. On 2/1/11 at 10:45 A.M., a skin assessment of	F 312	I. Corrective actions were made for the affected residents. Resident E was given incontinent care and barrier cream was applied. II. The facility recognizes that all residents have the potential to be affected by the alleged deficient practice. Residents with the potential to be affected were identified by audits of the ADL records, CNA assignment sheets, physicians orders, and plans of care. Corrections were made as necessary. III. The following actions were implemented to ensure that the alleged deficient practice does not recur:	

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F 312	Continued From page 8 Resident E was requested. The Assistant Director of Nursing, LPN # 1, and CNA # 1 assisted the resident from the chair. The resident's pants were saturated through with urine. The resident's brief was completely saturated. Resident E's buttocks and upper thighs were reddened and creased from the wet brief. CNA # 1 indicated at that time that the CNAs were "doing the best they could do." CNA # 1 indicated there were three CNAs and two nurses working the two floors that day. On 2/1/11 at 10:45 A.M., the Unit Manager indicated the floors did have a CNA call in that day, but the floors are staffed with either three or four CNAs. The clinical record of Resident E was reviewed on 2/1/11 at 11:00 A.M. Diagnoses included, but were not limited to, severe dementia. A Minimum Data Set [MDS] assessment, dated 1/10/11, indicated the resident had a short-term and long-term memory problem, was severely impaired in cognitive skills for daily decision-making, required extensive assistance of two plus staff for transfer, and extensive assistance of one staff for toilet use. The MDS assessment indicated Resident E was "Frequently incontinent" of bowel and bladder. A current care plan, dated 6/30/10, was provided by the MDS Coordinator on 2/1/11 at 1:00 P.M. The care plan indicated a "Focus" on "Alteration in elimination of bowel and bladder, Functional incontinence, Diuretic Use." The Interventions included, "Check and change q 2 h [every 2 hours] and prn [as needed]." On 2/1/11 at 2:00 P.M., CNA # 1 indicated she	F 312	(a) Education was provided to staff on providing timely incontinent care for residents dependent for toileting and personal hygiene. IV. The corrective actions will be monitored by audits of residents who are dependent for toileting and personal hygiene 3 times per week for 6 months and will be monitored through QA&A monthly meetings until corrections are no longer necessary. V. Corrections will be completed by March 4,2011.	

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F 312	Continued From page 9 had not gotten Resident E up that morning, but that she was already up at 7:30 A.M., when she reported for work. CNA # 1 indicated she was not sure when Resident E had gotten up, but she thought the resident was a "third shift get up." CNA # 1 indicated she had checked the resident for incontinence "some time" that morning, after she reported to work, and the resident had been dry. This federal tag relates to Complaint IN00085197. 3.1-38(a)	F 312		